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- (1) the length of stay for the Hospitalization exceeds twenty (20) cumulative *acute* days (not including days in a Distinct Part Psychiatric Unit);
- (2) the Hospital continues to fulfill its discharge planning duties as required in the Division's regulations;
- (3) the patient continues to need acute level care and is therefore **not** on Administrative Day status on any day for which an outlier payment is claimed;
- (4) the patient is not a patient in a Distinct Part Psychiatric Unit on any day for which an outlier payment is claimed; and
- (5) the patient is not a patient in a Non-Acute Unit within an Acute Hospital.

The outlier per diem payment amount is equal to sixty percent (60%) of the Hospital's enhanced transfer per diem.

10. Physician Payment

For physician services provided by Hospital-based physicians or Hospital-based entities to MassHealth patients, the Hospital will be reimbursed in accordance with, and subject, to the Physician Regulations at 130 CMR 433.000 et. seq. Such reimbursement shall be at the lower of the fee in the most current promulgation of the DHCFP fees as established in 114.3 CMR 16.00 (Surgery and Anesthesia Services), 17.00 (Medicine), 18.00 (Radiology) and 20.00 (Clinical Laboratory Services)¹, or the Hospital's usual and customary charge.

Hospitals will be reimbursed for such physician services only if the Hospital-Based Physician or a physician providing services on behalf of a Hospital-Based Entity took an active patient care role, as opposed to a supervisory role, in providing the Inpatient Service(s) on the billed date(s) of service. Physician services provided by residents and interns are reimbursed through the direct medical education (DME) portion of the SPAD payment and, as such, are not reimbursable separately. Hospitals will not be reimbursed separately from the SPAD and per diem payments for professional fees for practitioners other than Hospital-based physicians.

Hospitals shall not be reimbursed for inpatient physician services provided by Community-Based Physicians or Entities.

¹ The regulations referred to in this paragraph are voluminous, and will be provided upon request.

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11. Payments for Administrative Days

Payments for Administrative Days will be made on a per diem basis as described below. These per diem rates are all-inclusive and represent payment in full for all Administrative Days in all Acute Hospitals.

The AD rate is a base per diem payment and an ancillary add-on.

The base per diem payment is the median calendar year 2000 nursing home rate for all nursing home rate categories, as determined by DHCFP. This base rate is \$124.47.

The ancillary add-on is based on the ratio of ancillary charges to routine charges, calculated separately for Medicaid/Medicare Part B eligible patients and Medicaid-only eligible patients on AD status, using MassHealth paid claims for the period October 1, 1997 to September 30, 1998.

These ratios are 0.278 and 0.382, respectively. The resulting AD rates (base and ancillary) were then updated for inflation using the update factor of 2.0% for inflation between RY00 and RY01. Due to the start date of December 1, 2000, inflation between RY00 and RY01 will be adjusted to 2.4% for claims with dates of admission of December 1, 2000 through September 30, 2001. The resulting AD rates for RY01 are \$162.89 for Medicaid/Medicare Part B eligible patients and \$176.14 for Medicaid-only eligible patients.

A Hospital may receive outlier payments for patients who return to acute status from AD status after 20 cumulative acute days in a single hospitalization. That is, if a patient returns to acute status after being on AD status, the Hospital must add the acute days preceding the AD status to the acute days following the AD status in determining the day on which the Hospital is eligible for outlier payments. The Hospital may not bill for more than one SPAD if the patient fluctuates between acute status and AD status; the Hospital may only bill for one SPAD (covering 20 cumulative acute days), and then for Outlier Days, as described above.

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12. **Infant and Pediatric Outlier Payment Adjustments**

a. **Infant Outlier Payment Adjustment**

In accordance with 42 U.S.C. §1396a(s), the Division will make an annual infant outlier payment adjustment to Acute Hospitals for Inpatient Services furnished to infants under one year of age involving exceptionally high costs or exceptionally long lengths-of-stay. Hospitals will be reimbursed by the Division pursuant to the DHCFP Regulations at 114.1 CMR 36.05(3)(d) (attached as Exhibit 5).

b. **Pediatric Outlier Payment Adjustment**

In accordance with 42 U.S.C. §1396a(s), the Division will make an annual pediatric outlier payment adjustment to Acute Hospitals for Inpatient Services furnished to children greater than one year of age and less than six years of age if provided by a Hospital which qualifies as a disproportionate share Hospital under Section 1923(a) of the Social Security Act. (See Basic Federally-Mandated Disproportionate Share Adjustment, **Section IV.D.2**, for qualifying Hospitals.) Hospitals will be reimbursed by the Division pursuant to the DHCFP Regulations at 114.1 CMR 36.05(3)(c) (attached as Exhibit 5).

13. **Rehabilitation Unit Services in Acute Hospitals**

A per diem rate for rehabilitation services provided at an Acute Hospital shall apply only to Acute Hospital rehabilitation units operating at Public Service Hospitals in order to meet any remaining service needs following closure of a public rehabilitation Hospital.

The per diem rate for such rehabilitation services will equal the average MassHealth FY99 rehabilitation hospital rate adjusted for inflation. This rate represents the average MassHealth FY99 rehabilitation Hospital rate, weighted by volume of days, after removing the two lowest rates rehabilitation hospitals from the average. Acute Hospital administrative day rates will be paid for all days that a patient remains in the rehabilitation unit while not at acute or rehabilitation hospital level of care.

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14. SPAD Add-ons for Efficient Low Cost Hospitals

- a. Hospitals whose casemix-adjusted cost per discharge decreased between RY95 and RY98, as determined from the DHCFP 403 cost reports, are eligible for a SPAD add-on of \$30.61.
- b. Hospitals whose casemix-adjusted cost per discharge for RY98, as determined in **Section IV.B.2**, was below the efficiency standard of \$3,298.26, are eligible for a SPAD add-on of \$20.88.
- c. Hospitals eligible for both SPAD add-ons described in **Sections IV.B.14.a** and **b** above will receive those SPAD add-ons, as well as an additional SPAD add-on of \$78.32.

15. Perinatal Case Management Program Payments

Hospitals with DPH-designed neonatal intensive care units/Level III maternity units may qualify to receive an additional payment if they meet the Division's criteria for an integrated perinatal case management program. The Division will send all such Hospitals an application with instructions for applying for this payment. Hospitals that qualify for this payment will share \$1.5 million, prorated according to the Hospitals' relative MassHealth volume.

16. Emergency or Outpatient Department Visits which Result in an Inpatient Admission

Services provided to a Member in an Acute Hospital outpatient or Emergency Department on the same day as an inpatient admission of that patient to the same Hospital are reimbursed through the inpatient payment methodology only.

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C. REIMBURSEMENT FOR UNIQUE CIRCUMSTANCES

1. Sole Community Hospital

The RY01 standard inpatient payment amount per discharge for a Sole Community Hospital (as defined in **Section II**) shall be equal to the sum of:

95% of the Hospital's FY98 cost per discharge capped at 200% of the statewide average payment amount per discharge, adjusted for casemix and inflation; and the Hospital-specific RY01 pass-through amount per discharge, direct medical education amount per discharge, and the capital amount per discharge.

Derivation of RY01 per discharge costs is described in **Section IV.B.2**.

For RY01, adjustments were made for casemix by dividing the FY98 cost per discharge by the Hospital's FY98 all-payer casemix index and then multiplying the result by the Hospital's MassHealth casemix index for the period June 1, 1999 through May 31, 2000.

For RY01, adjustments were made for inflation by multiplying the casemix-adjusted payment amount by 1.9% to reflect inflation between RY98 and RY99, by 1.43% to reflect inflation between RY99 and RY00, and by 2.00% to reflect inflation between RY00 and RY01. Due to the start date of December 1, 2000, inflation between RY00 and RY01 will be adjusted to 2.4% for claims with dates of admission of December 1, 2000 through September 30, 2001.

There will also be outlier payments for patients whose length of stay during a single Hospitalization exceeds twenty acute days.

Acute Hospitals which receive payment as Sole Community Hospitals shall be determined by the Division.

2. Specialty Hospitals and Hospitals with Pediatric Specialty Units

For RY01, the standard inpatient payment amount per discharge for Specialty Hospitals and Hospitals with Pediatric Specialty Units (as defined in **Section II**) shall be equal to the sum of:

95% of the Hospital's FY98 cost per discharge capped at 200% of the statewide average payment amount per discharge, adjusted for casemix and inflation; and the Hospital-specific FY01 pass-through amounts per discharge, direct medical

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education amount per discharge and the capital amount per discharge. .

Derivation of RY01 per discharge costs is described in **Section IV.B.2.**

For RY01, adjustments were made for casemix by dividing the FY98 cost per discharge by the Hospital's FY98 all-payer casemix index and then multiplying the result by the Hospital's MassHealth casemix index for the period June 1, 1999 through May 31, 2000.

For RY01, adjustments were made for inflation by multiplying the casemix-adjusted payment amount by 1.9% to reflect inflation between RY98 and RY99, 1.43% to reflect inflation between RY99 and RY00, and by 2.00% to reflect inflation between RY00 and RY01. Due to the start date of December 1, 2000, inflation between RY00 and RY01 will be adjusted to 2.4% for claims with dates of admission of December 1, 2000 through September 30, 2001.

There will also be outlier payments for patients whose length of stay during a single hospitalization exceeds twenty acute days.

Acute Hospitals that receive payment as Specialty Hospitals and Pediatric Units shall be determined by the Division.

For Hospitals with Pediatric Specialty Units, the payment amount calculated under this section shall only apply to services rendered in the Pediatric Specialty Unit.

If data sources specified by the RFA are not available, or if other factors do not permit precise conformity with the provisions of the RFA, the Division shall select such substitute data sources or other methodology(ies) that the Division deems appropriate in determining rates in accordance with this section.

3. Public Service Hospitals and Municipal Hospital Providers

a. Public Service Hospital Providers

Public Service Hospitals shall be reimbursed for Inpatient Services as follows, and in accordance with **Section IV.C.3.b.(1)** For RY01, the standard inpatient payment amount per discharge for Public Service Hospital providers (as defined in **Section II**) shall be equal to the sum of:

95% of the Hospital's FY98 cost per discharge capped at 200% of the statewide average payment amount, adjusted for casemix and inflation; and the FY01 Hospital-specific pass-through amount per discharge, direct medical education

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amount per discharge and the capital amount per discharge.

Derivation of RY01 per discharge costs is described in Section IV.B.2.

For RY01, adjustments were made for casemix by dividing the FY98 cost per discharge by the Hospital's FY98 all-payer casemix index and then multiplying the result by the Hospital's MassHealth casemix index for the period June 1, 1999 through May 31, 2000.

For RY01, adjustments were made for inflation by multiplying the casemix-adjusted payment amount by 1.9% to reflect inflation between RY98 and RY99, by 1.43% to reflect inflation between RY99 and RY00, and by 2.00% to reflect inflation between RY00 and RY01. Due to the start date of December 1, 2000, inflation between RY00 and RY01 will be adjusted to 2.4% for claims with dates of admission of December 1, 2000 through September 30, 2001.

There will also be outlier payments for patients whose length of stay during a single Hospitalization exceeds twenty acute days.

Acute Hospitals that receive payment as Public Service Hospitals shall be determined by the Division

b. Municipal Acute Hospital Providers

Municipal Acute Hospitals that do not also qualify as Public Service Hospitals shall be reimbursed in accordance with Sections IV.B and IV.C.3.c. herein.

c. Supplemental Payment

Subject to the availability of federal financial participation, the Division shall make a supplemental payment in addition to the standard reimbursement made under the Division's Acute Hospital Contract, to recognize Public Service and Municipal Acute hospitals' extraordinary costs of serving MassHealth members. Such lump sum payments are made annually at the end of the applicable fiscal year, or at such other times after the effective date of this amendment as the Division may determine. The payment amount will be (i) determined by the Division using data filed by each qualifying hospital in its financial and cost reports, and (ii) a percentage of the difference between the qualifying hospital's total Medicaid costs and total Medicaid payments from any source, which percentage shall in no event exceed 100 percent.

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Acute hospitals that receive payment as public service hospital and municipal acute hospital providers shall be determined by the Division.

4. Non-Profit Teaching Hospitals Affiliated with a Commonwealth-Owned Medical School

- a. Subject to **Section IV.C.4.b**, the inpatient payment amount for non-psychiatric admissions at non-profit acute care teaching Hospitals affiliated with a Commonwealth-owned medical school shall be equal to the Hospital's cost per discharge calculated as follows. The data used for this payment will be from the most recent submission of the Hospital's or predecessor Hospital's DHCFF-403 report(s).

Total Hospital-specific inpatient non-psychiatric charges are multiplied by the Hospital's inpatient non-psychiatric cost-to-charge ratio (calculated using DHCFF-403, Schedule II, column 10, line 100 minus column 10, line 82 for the total cost numerator and schedule II, column 11, line 100 minus column 11, line 82 for the total charges denominator) to compute that facility's total inpatient non-psychiatric cost. The total inpatient non-psychiatric cost is then multiplied by the ratio of the Hospital-specific non-psychiatric MassHealth discharges to the total Hospital non-psychiatric discharges to yield the MassHealth inpatient non-psychiatric cost. The MassHealth inpatient non-psychiatric cost is then divided by the number of MassHealth non-psychiatric discharges to calculate the MassHealth cost per discharge. This MassHealth cost per discharge is multiplied by the inflation rates for those years between the year of the cost report and the current rate year, as set forth in **Section IV.B.2**.

- b. Any payment amount in excess of amounts which would otherwise be due any non-profit teaching Hospital affiliated with a state-owned medical school pursuant to **Section IV.B** is subject to specific legislative appropriation.

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D. Classification of Disproportionate Share Hospitals (DSHs) and Payment Adjustments

MassHealth will assist Hospitals that carry a disproportionate financial burden of caring for uninsured and publicly insured persons of the Commonwealth. In accordance with Title XIX rules and requirements, MassHealth will make an additional payment to Hospitals which qualify for such an adjustment under any one or more of the classifications listed below. Only Hospitals that have an executed Contract with the Division, pursuant to the RY01 RFA, are eligible for disproportionate share payments since the dollars are, in most cases, apportioned to the eligible group in relation to each other. MassHealth-participating Hospitals may qualify for adjustments and may receive them at any time throughout the Rate Year. If a Hospital's RFA Contract is terminated, its adjustment shall be prorated for the portion of RY01 during which it had a Contract with the Division. The remaining funds it would have received shall be apportioned to remaining eligible Hospitals. The following describes how Hospitals will qualify for each type of disproportionate share adjustment and the methodology for calculating those adjustments.

In accordance with federal and state law, Hospitals must have a MassHealth inpatient utilization rate of at least 1% to be eligible for any type of DSH payment, pursuant to DHCFP regulation at 114.1 CMR 36.07 (see Exhibit 6). Also, the total amount of DSH payment adjustments awarded to any Hospital shall not exceed the costs incurred during the year of furnishing Hospital services to individuals who are either eligible for medical assistance or have no health insurance or other source of third-party coverage, less payments received by the Hospital for medical assistance and by uninsured patients ("unreimbursed costs"), pursuant to 42 U.S.C. §1396r-4(g).

When a Hospital applies to participate in MassHealth, its eligibility and the amount of its adjustment shall be determined. As new Hospitals apply to become MassHealth providers, they may qualify for adjustments if they meet the criteria under one or more of the following DSH classifications. Therefore, some disproportionate share adjustments may require recalculation pursuant to DHCFP regulations set forth at 114.1 CMR 36.07 (see Exhibit 6). Hospitals will be informed if the adjustment amount will change due to reapportionment among the qualified group and will be told how overpayments or underpayments by the Division will be handled at that time.

To qualify for a DSH payment adjustment under any classification within **Section IV.D**, a Hospital must meet the obstetrical staffing requirements described in Title XIX at 42 U.S.C. §1396r-4(d) or qualify for the exemption described at 42 U.S.C. §1396r-4(d)(2). All DSH payments are subject to the availability of federal financial participation.

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1. High Public Payer Hospitals: Sixty-Three Percent Hospitals
(Total Annual Funding: \$11,700,000)

The eligibility criteria and payment formula for this DSH classification are specified by regulations of the Division of Health Care Finance and Policy (DHCFP) promulgated in accordance with M.G.L. c.118G § 11(a) (See 114.1 CMR 36.07(2) (attached as Exhibit 6), and pursuant to its Interagency Service Agreement (ISA) with the Division. For purposes of this classification only, the term "disproportionate share Hospital" refers to any Acute Hospital that exhibits a payer mix where a minimum of sixty-three percent of the Acute Hospital's gross patient service revenue is attributable to Title XVIII and Title XIX of the Federal Social Security Act, other government payers and free care. (See M.G.L. c. 118G §1.)

2. Basic Federally Mandated Disproportionate Share Adjustment
(Total Annual Funding: \$200,000)

The eligibility criteria and payment formula for this DSH classification are described regulations promulgated by DHCFP, pursuant to its ISA with the Division and in accordance with the minimum requirements of 42 U.S.C. §1396r-4. (See 114.1 CMR 36.07(3), attached as Exhibit 6).

3. Disproportionate Share Adjustment for Safety Net Providers

A disproportionate share safety net adjustment factor for all eligible hospitals shall be determined.

This class of hospital was identified and included to ensure that those hospitals that provide the services most critical to the poor are reimbursed for their overload of free care so that they can continue to provide the services that we deem crucial to the provision of adequate health care.

a. Determination of Eligibility

The disproportionate share adjustment for safety net providers is an additional payment for all hospitals eligible for the basic federally-mandated disproportionate share adjustment pursuant to Section IV.D.2. above, which also meet the following additional criteria:

- i. is a public hospital or a public service hospital;
- ii. has a volume of free care charges in FY93 that is at least 15% of total charges;

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iii. is an essential safety net provider in its service area, as demonstrated by delivery of services to populations with special needs, including persons with AIDS, trauma victims, high-risk neonates, and indigent patients without access to other providers;

iv. has completed an agreement with the Division of Medical Assistance for the federally-mandated disproportionate share adjustment for safety net providers.

b. **Payment Methodology**

An additional adjustment shall be calculated for federally-mandated disproportionate share hospitals that are eligible for the safety net provider adjustment.

i. This payment amount shall be reasonably related to the costs of services provided to patients eligible for medical assistance under Title XIX, or to low-income patients.

ii. This payment adjustment shall be based on an agreement between the Division and the qualifying hospital. The Division shall make a disproportionate share payment adjustment to the qualifying hospital; provided that such payment shall be adjusted if necessary, to ensure that a qualifying hospital's total disproportionate share adjustment payments for a fiscal year under the State Plan do not exceed 100% of such hospital's total unreimbursed free care and unreimbursed Medicaid costs for the same fiscal year. Such unreimbursed costs shall be calculated by the Division using the best data available, as determined by the Division for the fiscal year.

iii. The payment of the safety net adjustment to a qualifying hospital in any rate year shall be contingent upon the continued availability of federal financing participation for such payments.

4. Uncompensated Care Disproportionate Share Adjustment

Hospitals eligible for this adjustment are those acute facilities that incur "free care costs" as defined in DHCFP regulations pursuant to M.G.L. c.118G §18. The payment amounts for eligible Hospitals participating in the free care pool are determined and paid by DHCFP in accordance with its regulations at 114.6 CMR 11.00 (see Exhibit 6) and its ISA with the Division.

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5. Public Health Substance Abuse Disproportionate Share Adjustment

Hospitals eligible for this adjustment are those acute facilities that provide Hospital services to low-income individuals who are uninsured or are covered only by a wholly state-financed program of medical assistance of the Department of Public Health (DPH), in accordance with regulations set forth at 105 CMR 160.000 (attached as Exhibit 7) and DPH's ISA with the Division. The payment amounts for eligible Hospitals participating in the Public Health Substance Abuse program are determined and paid by DPH in accordance with regulations at 114.3 CMR 46.00 (attached as Exhibit 7) and DPH's ISA with the Division.

The rate methodology used to develop payment amounts for substance abuse inpatient hospital disproportionate share payments is a per diem fee schedule established and approved by the Division of Health Care Finance and Policy for inpatient acute substance abuse treatment services. This per diem is an all-inclusive per diem incorporating all medically necessary routine and ancillary services provided. The per diem rate is based on the costs from the freestanding community inpatient substance abuse treatment setting. These free standing inpatient community costs used to calculate the fee for inpatient acute substance abuse services are substantially less than the actual hospital based costs for the same services.

6. Disproportionate Share Adjustment for Acute Care Non-Profit Teaching Hospitals Affiliated with a State-Owned University Medical School

a. Eligibility

The Division shall determine a disproportionate share payment adjustment for non-profit acute care teaching Hospitals that have an affiliation with a Commonwealth-owned university medical school. In order to be eligible for this disproportionate share payment, the non-profit acute care teaching hospital must:

- (1) enter into an agreement with a state-owned university medical school to purchase from the medical school (a) such medical education activities as are described on Exhibit 9 attached hereto, (b) clinical support, and (c) clinical activities (collectively, "the purchased services");

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- (2) pay the state-owned university medical school for the purchased services in an amount which is the lower of (x) the medical school's costs for such purchased services or (y) an amount equal to the difference between (a) the aggregate reimbursement paid to the Hospital by the Division in accordance with **Section IV.C.4** above, **Section IV.C** of Attachment 4.19B(1), and this **Section IV.D.7**; and (b) the reimbursement which would otherwise have been paid to the Hospital by the Division if the Hospital were not affiliated with a state-owned university medical school.
- (3) have a common mission as established by state law, with the state-owned university medical school dedicated to train physicians, nurses and allied health professionals according to high professional ethical standards and to provide high quality health care services;
- (4) be the subject of an appropriation or authorization for this purpose.

b. Payment Amount

The Division provides eligible hospitals with instructions relative to the filing of cost reports necessary for calculation of the adjustment and calculates an adjustment for eligible Hospitals. This adjustment shall be reasonably related to the costs, volume or proportion of services provided to patients eligible for medical assistance under Title XIX or to low-income patients, and equals the amount of funds specified in an agreement between the Division of Medical Assistance and relevant governmental unit. For purposes of this adjustment, the Division shall deem the costs of the medical and paramedical education services specified in Exhibit 9 to constitute costs of services provided by the Hospital to patients eligible for medical assistance under Title XIX, or to low-income patients. This disproportionate share adjustment will reimburse only those costs that have not otherwise been reimbursed and will be paid subject to the availability of federal financial participation.

7. Disproportionate Share Adjustment for Pediatric Specialty Hospitals and Hospitals with Pediatric Specialty Units

The eligibility criteria and payment formula for this DSH classification are specified by regulations of DHCFP, promulgated in accordance with M.G.L. c. 118G §11(a) (see 114.1 CMR 36.07(8) attached as Exhibit 6). In order to be

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eligible for this adjustment, the Hospital must be a Pediatric Specialty Hospital or Hospital with a Pediatric Specialty Unit as defined **Section II**. In addition, the Hospital must have a signed Contract with the Division for the period that such adjustment is in effect. The availability of and total amount of funds allocated for payment in accordance with this paragraph are subject to specific legislative appropriation.

E. Upper Limit Review and Federal Approval

Payment adjustments may be made for reasons relating to the Upper Limit, if the number of hospitals that apply and qualify changes, if updated information necessitates a change, or as otherwise required by the Health Care Financing Administration (HCFA).

If any portion of the reimbursement methodology is not approved by HCFA, the Division may recoup or offset against future payments, any payment made to a Hospital in excess of the approved methodology.

F. Treatment of Reimbursement for Members in the Hospital on the Effective Date of the Hospital Contract

Except where payments are made on a per diem basis, reimbursement to participating Hospitals for services provided to MassHealth members who are at acute inpatient status prior to December 1, 2000 and who remain at acute inpatient status on or after December 1, 2000 shall continue to be reimbursed at the Hospital's RY00 rates. Reimbursement to participating Hospitals for services provided to MassHealth members who are admitted on or after December 1, 2000 shall be reimbursed at the RY01 Hospital rates.

G. Future Rate Years

Adjustments may be made each Rate Year to update rates and shall be made in accordance with the Hospital Contract in effect on that date.

H. Errors in Calculation of Pass-through Amounts, Direct Medical Education Cost or Capital Costs

If a transcription error occurred or if the incorrect line was transcribed in the calculation of the RY01 pass-through costs, direct medical education costs or capital costs, resulting in an amount not consistent with the methodology, a correction can be made upon agreement by both parties. Such corrections will be made to the final Hospital-specific rate retroactive to the start of the rate year but will not affect computation of the statewide average payment amount or of any of the efficiency standards applied to inpatient and outpatient costs, or to capital costs.

TN 00-14
Supersedes TN 99-12, 00-10

Approval Date AUG 28 2001
Effective Date 12/1/00

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I. New Hospitals/Hospital Change of Ownership

For any newly participating Hospital, or any Hospital which is party to a merger, sale of assets, or other transaction involving the identity, licensure, ownership or operation of the Hospital, the Division, in its sole discretion, shall determine, on a case by case basis (1) whether the Hospital qualifies for reimbursement under the RFA, and, if so, (2) the appropriate rates of reimbursement. Such rates of reimbursement shall be determined in accordance with the provisions of the RFA to the extent the Division deems possible. The Division's determination shall be based on the totality of the circumstances. Any such rate may, in the Division's sole discretion, affect computation of the statewide average payment amount and/or any efficiency standard.

J. Data Sources

If data sources specified in the RFA are not available, or if other factors do not permit precise conformity with the provisions of the RFA, the Division may select such substitute data sources or other methodology(ies) that the Division deems appropriate in determining Hospitals' rates.

TN 00-14
Supersedes TN 99-12, 00-10

AUG 28 2001
Approval Date _____
Effective Date 12/1/00

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Exhibit 1

130 CMR 415.415 and 415.416

AUG 23 2001
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130 CMR: DIVISION OF MEDICAL ASSISTANCE

415.414: Utilization Review

(A) All inpatient services must be provided in accordance with 130 CMR 450.204 or 130 CMR 415.415, and are subject, among other things, to utilization review under 130 CMR 450.207 through 130 CMR 450.209 and to requirements governing overpayments under 130 CMR 450.235(B) and 450.237.

(B) (1) The Division (or its agent) will review inpatient services provided to members to determine the medical necessity, pursuant to 130 CMR 450.204, or administrative necessity and appropriateness, pursuant to 130 CMR 415.415, of such services. Any such review may be conducted prior to, concurrently, or retrospectively following the member's inpatient admission. Reviewers consider the medical-record documentation of clinical information available to the admitting provider at the time the decision to admit was made. Reviewers do not deny admissions based on what happened to the member after the admission. However, if an admission was not medically necessary at the time of the decision to admit, but the medical record indicates that an inpatient admission later became medically necessary, the admission will be approved as long as all other Division requirements are met. (2) If, pursuant to any review, the Division concludes that the inpatient admission was not medically or administratively necessary, the Division will deny payment for the inpatient admission.

(3) If the Division issues a denial notice for an acute inpatient hospital admission pursuant to 130 CMR 415.414 and 450.204 as well as either 130 CMR 450.209 or 450.237, the hospital may rebill the claim as an outpatient service, as long as the Division has determined the service would have been appropriately provided in an outpatient setting. In order for the hospital to receive payment under 130 CMR 415.414(B)(3), the outpatient claim and a copy of the denial notice must be received by the Division within 90 days from the date of the denial notice and must comply with all applicable Division requirements.

(C) To support the medical necessity of an inpatient admission, the provider must adequately document in the member's medical record that a provider with applicable expertise expressly determined that the member required services involving a greater intensity of care than could be provided safely and effectively in an outpatient setting. Such a determination may take into account the amount of time the member is expected to require inpatient services, but must not be based solely on this factor. The decision to admit is a medical determination that is based on factors, including but not limited to the:

- (1) member's medical history;
- (2) member's current medical needs;
- (3) severity of the signs and symptoms exhibited by the member;
- (4) medical predictability of an adverse clinical event occurring with the member;
- (5) results of outpatient diagnostic studies;
- (6) types of facilities available to inpatients and outpatients; and
- (7) Division's Acute Inpatient Hospital Admission Guidelines in Appendix F of the *Acute Inpatient Hospital Manual* and in various appendices of other appropriate provider manuals. The Division has developed such guidelines to help providers determine the medical necessity of an acute inpatient hospital admission. These guidelines indicate when there is generally no medical need for such an admission.

(D) If, as the result of any review, the Division determines that any hospital inpatient admission, stay, or service provided to a member was not covered under the member's coverage type (see 130 CMR 450.105) or was delivered without obtaining a required authorization including, where applicable, authorization from the member's primary-care provider, the Division will not pay for that inpatient admission, stay, or service.

415.415: Reimbursable Administrative Days

(A) Administrative days as defined in 130 CMR 415.402 are reimbursable if the following conditions are met:

- (1) the recipient requires an admission to a hospital or a continued stay in a hospital for reasons other than the need for services that can only be provided in an acute inpatient hospital as defined in 130 CMR 415.402 (see 130 CMR 415.415(B) for examples); and

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130 CMR: DIVISION OF MEDICAL ASSISTANCE

415.415: continued

(2) a hospital is making regular efforts to discharge the recipient to the appropriate setting. These efforts must be documented according to the procedures described in 130 CMR 450.205. The regulations covering discharge-planning standards described in 130 CMR 415.419 must be followed, but they do not preclude additional, effective discharge-planning activities.

(B) Examples of situations that may require hospital stays at less than a hospital level of care include, but are not limited to, the following.

- (1) A recipient is awaiting transfer to a chronic disease hospital, rehabilitation hospital, nursing facility, or any other institutional placement.
- (2) A recipient is awaiting arrangement of home services (nursing, home health aide, durable medical equipment, personal care attendant, therapies, or other community-based services).
- (3) A recipient is awaiting arrangement of residential, social, psychiatric, or medical services by a public or private agency.
- (4) A recipient with lead poisoning is awaiting deleading of his or her residence.
- (5) A recipient is awaiting results of a report of abuse or neglect made to any public agency charged with the investigation of such reports.
- (6) recipient in the custody of the Department of Social Services is awaiting foster care when other temporary living arrangements are unavailable or inappropriate.
- (7) A recipient cannot be treated or maintained at home because the primary caregiver is absent due to medical or psychiatric crisis, and a substitute caregiver is not available.
- (8) A recipient is awaiting a discharge from the hospital and is receiving skilled nursing or other skilled services. Skilled services include, but are not limited to:
 - (a) maintenance of tube feedings;
 - (b) ventilator management;
 - (c) dressings, irrigations, packing, and other wound treatments;
 - (d) routine administration of medications;
 - (e) provision of therapies (respiratory, speech, physical, occupational, etc.);
 - (f) insertion, irrigation, and replacement of catheters; and
 - (g) intravenous, intramuscular, or subcutaneous injections, or intravenous feedings (for example, total parenteral nutrition.)

415.416: Nonreimbursable Administrative Days

Administrative days are not reimbursable when:

- (A) a hospitalized recipient is awaiting an appropriate placement or services that are currently available but the hospital has not transferred or discharged the recipient because of the hospital's administrative or operational delays;
- (B) the Division or its agent determines that appropriate noninstitutional or institutional placement or services are available within a reasonable distance of the recipient's noninstitutional (customary) residence and the recipient, the recipient's family, or any person legally responsible for the recipient refuses the placement or services; or
- (C) the Division or its agent determines that appropriate noninstitutional or institutional placement or services are available within a reasonable distance of the recipient's noninstitutional (customary) residence and advises the hospital of the determination, and the hospital or the physician refuses or neglects to discharge the recipient.

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**State Plan Under Title XIX of the Social Security Act
State: Massachusetts
Institutional Reimbursement**

Exhibit 2

130 CMR 415.414

Appendix F to Inpatient Hospital Manual

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